Rec'd

$16,658.46

1984

Form 712
10013 (Rev. October 1981)
Department of the Treasury
Internal Revenue Service

Life Insurance Statement

Part I Decedent—Insured (File with Federal Estate Tax Return, Form 706)

1 Decedent's first name and middle initial Walter L.	2 Decedent's last name Huber	3 Decedent's social security number (if known) 536-10-4978	4 Date of death 03/06/84

5 Name and address of insurance company: ☒ The Mutual Life Insurance Company of N.Y. ☐ MONY Life Insurance Co. of America
One MONY Plaza, P.O. Box 4830, Syracuse, N.Y. 13221

6 Kind of policy Life	7 Policy number 844 18 45

8 Owner's name. If decedent is not the owner, please attach copy of application. Walter L. Huber	9 Date issued 07/29/59	10 Assignor's name. Please attach copy of assignment.
11 Date assigned	12 Value of the policy at the time of assignment	13 Amount of premium. 560.38 Annual

14 Names of beneficiaries

Verna L. Huber

15 Face amount of policy	$ 10000.00
16 Indemnity benefits	$
17 Additional insurance	$ 5206.00
18 Other benefits Term Divid.	$ 300.00
19 Principal of any indebtedness to the company deductible in determining net proceeds	$
20 Interest on indebtedness (item 19) accrued to date of death	$
21 Amount of accumulated dividends	$
22 Amount of post-mortem dividends	$ 400.94
23 Amount of returned premium	$ 186.80
24 Amount of proceeds if payable in one sum	$ 16093.74
25 Value of proceeds as of date of death (if not payable in one sum)	$

26 Policy provisions concerning deferred payments or installments.
Note: *If other than lump-sum settlement is authorized for a surviving spouse, please attach a copy of the insurance policy.*

27 Amount of installments $

28 Date of birth, sex, and name of any person the duration of whose life may measure the number of payments.

29 Amount applied by the insurance company as a single premium representing the purchase of installment benefits $

30 Basis (Mortality table and rate of interest) used by insurer in valuing installment benefits.

31 Was the insured the annuitant or beneficiary of any annuity contract issued by the company? ☐ **Yes** ☐ **No**

32 Names of companies with which decedent carried other policies and amount of such policies if this information is disclosed by your records.

The undersigned officer of the above-named insurance company hereby certifies that this statement sets forth true and correct information.

Signature ▶ Justin M. Zinack Title ▶ **Assistant Director of Regular Benefit Payment** Date of Certification ▶ 03/22/84
th

Instructions

Paperwork Reduction Act Notice.—The Paperwork Reduction Act of 1980 says we must tell you why we are collecting this information, how we will use it, and whether you have to give it to us. We ask for the information to carry out the Internal Revenue laws of the United States. We need it to ensure that you are complying with these laws and to allow us to figure and collect the right amount of tax. You are required to give us this information.

Statement of Insurer.—This statement must be made, on behalf of the insurance company which issued the policy, by an officer of the company having access to the records of the company. For purposes of this statement, a facsimile signature may be used in lieu of a manual signature and if used, shall be binding as a manual signature.

Separate Statements.—A separate statement must be filed for each policy.

$7241.85 Rec'd

1984

Form 712
10013 (Rev. October 1981)
Department of the Treasury
Internal Revenue Service

Life Insurance Statement

Part I Decedent—Insured (File with Federal Estate Tax Return, Form 706)

1 Decedent's first name and middle initial: Walter L.

2 Decedent's last name: Huber

3 Decedent's social security number (if known): 536-10-4978

4 Date of death: 03/06/84

5 Name and address of insurance company: ☒ The Mutual Life Insurance Company of N.Y. ☐ MONY Life Insurance Co. of America
One MONY Plaza, P.O. Box 4830, Syracuse, N.Y. 13221

6 Kind of policy: Life

7 Policy number: 580 28 78

8 Owner's name. If decedent is not the owner, please attach copy of application.: Walter L. Huber

9 Date issued:

10 Assignor's name. Please attach copy of assignment.:

11 Date assigned:

12 Value of the policy at the time of assignment:

13 Amount of premium.: 132.30 Annual

14 Names of beneficiaries

Verna L. Huber
In accordance with mode of settlement endorsed in policy.

15 Face amount of policy	$ 5000.00
16 Indemnity benefits	$
17 Additional insurance	$ 2252.00
18 Other benefits Term Divid.	$ 150.00
19 Principal of any indebtedness to the company deductible in determining net proceeds	$
20 Interest on indebtedness (item 19) accrued to date of death	$
21 Amount of accumulated dividends	$
22 Amount of post-mortem dividends	$ 133.55
23 Amount of returned premium	$ 66.18
24 Amount of proceeds if payable in one sum	$ 7601.73
25 Value of proceeds as of date of death (if not payable in one sum)	$

26 Policy provisions concerning deferred payments or installments.
Note: *If other than lump-sum settlement is authorized for a surviving spouse, please attach a copy of the insurance policy.*

27 Amount of installments $

28 Date of birth, sex, and name of any person the duration of whose life may measure the number of payments.

29 Amount applied by the insurance company as a single premium representing the purchase of installment benefits $

30 Basis (Mortality table and rate of interest) used by insurer in valuing installment benefits.

31 Was the insured the annuitant or beneficiary of any annuity contract issued by the company? ☐ **Yes** ☐ **No**

32 Names of companies with which decedent carried other policies and amount of such policies if this information is disclosed by your records.
Equitable $1000.00

The undersigned officer of the above-named insurance company hereby certifies that this statement sets forth true and correct information.

Signature ► Justin M. Zinack
Title ► Assistant Director of Regular Benefit Payment
Date of Certification ► 03/22/84
th

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Separate Statements.—A separate statement must be filed for each policy.

MEMBER'S STATEMENT

ACCOUNT NO.	582 04	PAGE	1
SOCIAL SECURITY NO.	532 34 0754		
STATEMENT PERIOD: FROM	01/01/84	TO	06/30/84

MEMBER

VERNA L HUBER
4208 218TH E
SUMNER WA 98390

PLEASE NOTIFY CREDIT UNION OF ADDRESS CHANGE

DIRECT INQUIRIES TO

HEALTH CARE CREDIT UNION
315 SOUTH K STREET
TACOMA WA 98405

OR CALL THIS NUMBER

206 597 7726

TO CONFIRM PREAUTHORIZED TRANSFERS, PLEASE CALL 206 597 7726

ACTIVITY		SHARE ACCOUNT		LOAN ACCOUNT			
DATE MO. DAY YR	TRANSACTION DESCRIPTION	AMOUNT	BALANCE	AMOUNT	FINANCE CHARGE (INTEREST ONLY)	PRINCIPAL	BALANCE
	PREVIOUS BALANCE		1320 65				
02 16 84	WITHDRAWL-CHECK	1320 65-	00				
	NEW BALANCE		00				

DIVIDEND DECLARED	YEAR TO DATE DIVIDEND	YEAR TO DATE FINANCE CHRG.	INTEREST REFUND

SPLIT RATE%

MONEY TALKS: SAVE SOME BEFORE IT SAYS "GOODBYE" ITS INSURED UP TO $100,000.
SHARE ACCOUNT NON-TRANSFERABLE AS DEFINED IN 12 CFR PART 204 (REGULATION D).

NOTICE: SEE REVERSE SIDE AND ACCOMPANYING STATEMENT(S) FOR IMPORTANT INFORMATION.

IMPORTANT INFORMATION ABOUT YOUR STATEMENT

1. EXPLANATION OF FINANCE CHARGES

The FINANCE CHARGE for a loan is made up of two parts:
(1) Interest, and (2) certain other fees.

Interest is computed by applying a periodic rate to each outstanding unpaid principal loan balance for the exact number of days each balance is outstanding. The applicable periodic rates and their corresponding ANNUAL PERCENTAGE RATES are ordinarily itemized and identified on the face of this statement; in some cases, however, this information may be found on a separate sheet enclosed with this statement.

Normally, the only type of FINANCE CHARGE which will be imposed when you make a loan payment is interest. However, on those occasions when other fees (which are also FINANCE CHARGES) are imposed, your statement will specifically itemize and identify those other fees.

2. IN CASE OF ERRORS OR INQUIRIES ABOUT YOUR STATEMENT OF LOAN ACCOUNT

Send your inquiry in writing so that the credit union receives it within 60 days after this statement was mailed to you. Your written inquiry must include:

1. Your name and account number.
2. A description of the error and why (to the extent you can explain) you believe it is an error.
3. The dollar amount of the suspected error.

If you have authorized your credit union to automatically make your payment(s) from your checking or savings account, you can stop or reverse payment on any amount you think is wrong by mailing your notice so that the credit union receives it within 16 days after the statement was sent to you.

You remain obligated to pay the portion of your account not in dispute, but you do not have to pay any amount in dispute during the time the credit union is resolving the dispute. During that same time the credit union may not take any action to collect disputed amounts or report disputed amounts as delinquent.

This is a summary of your rights. A full statement of your rights and the credit union's responsibilities under the Federal Fair Credit Billing Act will be sent to you upon request and in response to a statement error notice.

3. *IN CASE* OF ERRORS OR QUESTIONS ABOUT YOUR ELECTRONIC TRANSFERS

Write or telephone us at the address or phone number shown on the face of this statement as soon as you can, if you think your statement or receipt is wrong or if you need more information about a transfer on the statement or receipt. We must hear from you no later than 60 days after we sent you the FIRST statement on which the error or problem appeared.

1. Tell us your name and account number.
2. Describe the error or the transfer you are unsure about, and explain as clearly as you can why you believe there is an error or why you need more information.
3. Tell us the dollar amount of the suspected error.

We will investigate your complaint and will correct any error promptly. If we take more than 10 days to do this, we will recredit your account for the amount you think is in error, so that you will have use of the money during the time it takes us to complete our investigation.

4. EXPLANATION OF STATEMENT DATES

The dates shown on this statement are the dates the credit union posted the amounts to your account.

5. CREDIT BALANCE ON LOAN ACCOUNT

If a minus sign (-) appears in the Balance column of your loan account, it means you have a credit balance.

6. KEEP THIS STATEMENT FOR INCOME TAX PURPOSES

Dividends or interest earned this year in excess of $10.00 will be reported to the Internal Revenue Service as interest. All dividends or interest earned should be reported on your income tax return.

9-80

MEMBER'S STATEMENT

ACCOUNT NO. 83 04

PAGE 1

SOCIAL SECURITY NO. 536 10 4978

STATEMENT PERIOD: FROM 01/01/84 TO 06/30/84

MEMBER

WALTER L HUBER
4208 218TH E
SUMNER WA 98390

PLEASE NOTIFY CREDIT UNION OF ADDRESS CHANGE

DIRECT INQUIRIES TO

HEALTH CARE CREDIT UNION
315 SOUTH K STREET
TACOMA WA 98405

OR CALL THIS NUMBER

206 597 7726

TO CONFIRM PREAUTHORIZED TRANSFERS, PLEASE CALL
206 597 7726

ACTIVITY		SHARE ACCOUNT		LOAN ACCOUNT			
DATE MO. DAY YR	TRANSACTION DESCRIPTION	AMOUNT	BALANCE	AMOUNT	FINANCE CHARGE (INTEREST ONLY)	PRINCIPAL	BALANCE
	PREVIOUS BALANCE		127649				
021684	WITHDRAWL-CHECK	127649-	00				
	NEW BALANCE		00				

DIVIDEND DECLARED

YEAR TO DATE DIVIDEND

YEAR TO DATE FINANCE CHRG.

INTEREST REFUND

SPLIT RATE%

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9-80

MEMBER'S STATEMENT

ACCOUNT NO. 582 04

PAGE 1

SOCIAL SECURITY NO. 532 34 0754

STATEMENT PERIOD: FROM 07/01/83 TO 12/31/83

MEMBER
VERNA L HUBER
4208 VANDERMARK RD E
SUMNER WA 98390

PLEASE NOTIFY CREDIT UNION OF ADDRESS CHANGE

DIRECT INQUIRIES TO
T. G. CREDIT UNION
315 SOUTH K STREET
TACOMA WA 98405

OR CALL THIS NUMBER
206 597 7726

TO CONFIRM PREAUTHORIZED TRANSFERS, PLEASE CALL
206 597 7726

ACTIVITY		SHARE ACCOUNT		LOAN ACCOUNT			
DATE MO. DAY YR	TRANSACTION DESCRIPTION	AMOUNT	BALANCE	AMOUNT	FINANCE CHARGE (INTEREST ONLY)	PRINCIPAL	BALANCE
	PREVIOUS BALANCE		127921				
123183	DIVIDEND	4144	132065				
	NEW BALANCE		132065				

DIVIDEND DECLARED: SPLIT RATE%

YEAR TO DATE DIVIDEND: 81.57

YEAR TO DATE FINANCE CHRG.:

INTEREST REFUND:

ANNUAL MEET FEB 25 1984 DORIC 6:30 PM SAVE MORE IN 84 JOIN OUR XMAS CLUB
SHARE ACCOUNT NON-TRANSFERABLE AS DEFINED IN 12 CFR PART 204 (REGULATION D).

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MEMBER'S STATEMENT

ACCOUNT NO.	83 04	PAGE	1
SOCIAL SECURITY NO.	536 10 4978		
STATEMENT PERIOD: FROM	07/01/83	TO	12/31/83

MEMBER

WALTER L HUBER
4208 VANDERMARK RD E
SUMNER WA 98390

PLEASE NOTIFY CREDIT UNION OF ADDRESS CHANGE

DIRECT INQUIRIES TO

T. G. CREDIT UNION
315 SOUTH K STREET
TACOMA WA 98405

OR CALL THIS NUMBER

206 597 7726

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ACTIVITY		SHARE ACCOUNT		LOAN ACCOUNT			
DATE MO. DAY YR	TRANSACTION DESCRIPTION	AMOUNT	BALANCE	AMOUNT	FINANCE CHARGE (INTEREST ONLY)	PRINCIPAL	BALANCE
	PREVIOUS BALANCE		123636				
123183	DIVIDEND	4013	127649				
	NEW BALANCE		127649				

DIVIDEND DECLARED	SPLIT RATE%	YEAR TO DATE DIVIDEND	78.96
YEAR TO DATE FINANCE CHRG.		INTEREST REFUND	

ANNUAL MEET FEB 25 1984 DORIC 6:30 PM SAVE MORE IN 84 JOIN OUR XMAS CLUB
SHARE ACCOUNT NON-TRANSFERABLE AS DEFINED IN 12 CFR PART 204 (REGULATION D).

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Dividends or interest earned this year in excess of $10.00 will be reported to the Internal Revenue Service as interest. All dividends or interest earned should be reported on your income tax return.

GMAC
FINANCING

We uncomplicate things

Hospital out patient
2/16/84
Paid in full.

E-562

CONTAINS RECYCLED MATERIALS
INDUSTRY CONSUMER COOPERATION FOR A BETTER ENVIRONMENT

STATEMENT OF ACCOUNT

PAYMENTS AND CHARGES RECEIVED AFTER THE DATE OF THIS STATEMENT WILL BE REFLECTED ON THE NEXT STATEMENT

PATIENT HUBER ,WALTER L LAST STMT. 02/21/84 PREVIOUS BALANCE 267.20

DATES	SERVICES	AMOUNTS
03/12/84	MEDICARE PAYMENT	166.94-
03/12/84	CONT ADJ MED B	46.82-

.00 MEDICARE B A34 EST. INS. DUE .00
.00 .00

FOR INFORMATION TELEPHONE 206-594-1133
STMT. DATE 03/22/84
ADM. DATE 02/16/84
CURR. ACCT. BALANCE 53.44

DISCHARGE DATE	PREVIOUS BALANCE	ADDED CHARGES	PATIENT PAYMENT & ADJ.	INSURANCE PAYMENT & ADJ.	ESTIMATED INSURANCE DUE
	267.20	.00	.00	213.76-	.00

GUARANTOR
WALTER L HUBER
4208 218 EAST
SUMNER WA 98390

R 6314991
PATIENT NUMBER-REFER TO THIS NUMBER ON ALL INQUIRIES

PAY THIS AMOUNT 53.44

MAKE CHECK PAYABLE AND REMIT TO
TACOMA GENERAL U40-MULTICARE
P.O. BOX 5277
TACOMA, WASH 98405

[redacted]

[redacted]

Blue Cross
of Washington and Alaska

03/29/84

P.O. Box 327
Seattle, Washington 98111
(206) 367-1000

Explanation of Benefits

Subscriber:
WALTER HUBER
4208 218TH EAST
SUMNER
WA 98390

Patient: WALTER HUBER
Provider: TACOMA GEN HOSP
Claim Number: 4068017918
Date(s) of Service: 02/16/84--02/16/84

This form explains how we processed your recent claim. It is not a billing. If you disagree with the disposition of your claim and our Customer Service Department confirms the original denial, you may request *in writing* a formal review of your claim.		**Benefit Calculations**	**Your Blue Cross Program Pays**
1. Total Charge by Your Provider of Care		267.20	
2. **Basic Benefits Provided by Your Program** HOSPITAL SERVICES			53.44
3. **Total Basic Payment**			53.44
4. Balance of Charges			
5. Less Charges Not Allowed Under the Provisions of Your Program		213.76	
Remarks: THE NON-ALLOWABLE CHARGE REPRESENTS THE AMOUNT PAYABLE BY YOUR OTHER CARRIER, THE AMOUNT CREDITED TOWARD YOUR MAJOR MEDICAL DEDUCTIBLE (IF APPLICABLE) AND ANY AMOUNT NOT COVERED BY EITHER CARRIER.			
6. **Major Medical Benefits Provided by Your Program**	Eligible Expense		
7. Amount of Deductible Required by Your Program			
8. Amount of Your Deductible Previously Satisfied			
9. Amount Credited to Your Deductible on This Claim			
10. Total Amount Eligible for Payment After Your Deductible is Satisfied			
11. **Major Medical Benefits are Payable at % of the Amount Shown in Line 10 Above**			
12. **Total Blue Cross Payment to be Sent to Your Provider**			53.44

To date this **has satisfied** **of the** **deductible for 19**

When inquiring about your claim, always give your group and identification numbers.

Group No. NCOAS Subscriber Identification No. 000093895

84.052 23.47.13 0656 0074 0

A

TACOMA GENERAL HOSPITAL 91-1088895-A U46
P.O. BOX 5277
TACOMA, WASH 98405
206 594-1133

PAGE NO.	1
HOSP. NO.	

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
OUTP.	02/21/84	

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
HUBER ,WALTER L	6314991	M		02/16/84			

GUARANTOR NAME AND ADDRESS

WALTER L HUBER
4208 218 EAST
SUMNER WA 98390

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
0	MEDICARE B A34		536104978A

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
2/16	BONE COMPLETE SUR	4907825	182.30	182.30				
2/16	SPINE LUMBOSAC AP	6007210	49.00	49.00				
2/16	PELVIS AP BOTH HI	6007217	35.90	35.90				
BALANCE FORWARD								
SUMMARY OF CURRENT CHARGES								
	RADIOLOGY	4140	84.90	84.90				
	NUCLEAR MED	4160	182.30	182.30				
SUB-TOTAL OF CURR. CHARGES			267.20	267.20				
POLICY DEDUCTIBLE				75.00-				75.00
COINSURANCE				38.44-				38.44
TOTALS			267.20	153.76				[illegible]

MEDICARE HAS BEEN BILLED 267.20

OTHER INSURANCE BILLED Blue Cross

AFTER MEDICARE PAYMENT YOU WILL RECEIVE A MONTHLY STATEMENT UNTIL YOUR ACCOUNT IS PAID IN FULL.

PATIENT NUMBER 6314991

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT [illegible]

TACOMA GENERAL HOSPITAL 91-1088895-A U46
TACOMA, WASH

CONDITIONS OF ADMISSION TO TACOMA GENERAL HOSPITAL
PLEASE READ CAREFULLY — THEN SIGN WHERE INDICATED BELOW

PATIENT'S NAME: ~~2-16-84~~ HUBER WALTER L   ACCOUNT NUMBER: 631499 1

1. CONSENT TO TREATMENT: I hereby authorize Tacoma General Hospital to render all necessary medical care (to me) to my ____________ including X-ray examinations, laboratory tests or specific procedures considered necessary by the attending physician.

   The hospital as a teaching institution provides supervised experience to students of health care occupations. You may occasionally be attended by a student in the course of your daily care and treatment.

2. RELEASE OF INFORMATION: I authorize the hospital to disclose the following information to third party payors and funding sources to obtain payment for billing: Copies of History and Physical consultations, Emergency and Discharge summary reports of specific treatment and diagnostic procedures. This consent may be revoked at any time. Unless earlier revoked, shall expire 6 months from date listed below.

3. PERSONAL VALUABLES: The hospital maintains a safe for the safekeeping of money and valuables, and shall not be liable for loss or damage to any personal property retained by the patient during hospitalization.

4. REMOVAL OF PATIENT: Authorization is hereby given for the removal of this patient from the hospital for necessary special diagnostic procedures and/or treatment, as required by the attending physician. The hospital shall not be held responsible for the safety of the patient during transport to another facility for special procedures and treatment ordered by the physician.

5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all appropriate insurance benefits and proceeds to the hospital for application on my bill.

6. **FINANCIAL AGREEMENT:** In consideration of the extension of credit by Tacoma General Hospital, I promise to pay for hospital services rendered to the patient above named. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

FOR MEDICARE PATIENTS ONLY

Authorization to Release Information and Payment Request. I certify that the information given by me in applying for payment under the appropriate titles of the Social Security Act of H.B. 89-97 is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductible and 20 percent of the remaining reasonable charges.

For outpatient services, I request that this authorization apply to the anticipated period of treatment but not to exceed one (1) year.

NOTICE TO OBLIGATOR: (a) Do not sign this charge agreement before you read it.
OBLIGATOR ACKNOWLEDGES RECEIPT OF A COMPLETED COPY OF THIS AGREEMENT

Dated 2-16-84   Signed: x W. Huber
OBLIGOR

Adm. Officer or
Accounts counselor B Vanderkloop   x ____________
OBLIGOR

GMAC
FINANCING

We uncomplicate things

Inpatient Hospital
12/27 - 12/31-83

Paid in full.

E-562

CONTAINS RECYCLED MATERIALS
INDUSTRY CONSUMER COOPERATION FOR A BETTER ENVIRONMENT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES/HEALTH CARE FINANCING ADMINISTRATION

MEDICARE HOSPITAL, SKILLED NURSING FACILITY AND HOME HEALTH BENEFITS RECORD

500129 DATE: 03/09/84

WALTER L HUBER
4208 218TH E
SUMNER WA 98390

HEALTH INSURANCE CLAIM NUMBER
536-10-4978A

Always use this number when writing about your claim

THIS IS NOT A BILL

No action is required of you upon receipt of this notice. This notice is to give you a record of the Medicare benefits you used during the period shown in item 1. For important additional information please see the other side of this form.

1 OUR RECORDS SHOW THAT YOU RECEIVED THESE SERVICES

Type of Services	Services Were Provided By	Date
INPATIENT HOSPITAL	TACOMA HOSP DIV CONSOLIDATED HOSP 315 SOUTH K TACOMA WA 98405	12/27/83 THRU 12/31/83

2 MEDICARE HAS PAID FOR ALL COVERED SERVICES EXCEPT

$304.00 FOR THE INPATIENT DEDUCTIBLE.

If you have any questions about this record, call or write.

BLUE CROSS OF WASHINGTON/ALASKA INC
15700 DAYTON AVENUE NORTH PO BOX 327
SEATTLE WASHINGTON 98111
TELEPHONE NUMBER: 1-206-361-3121

3 OUR RECORDS SHOW THE FOLLOWING BENEFITS WERE USED THIS TIME

Inpatient Hospital Days	Lifetime Reserve Days	Skilled Nursing Facility Days	Home Health Visits Hospital Insurance	Home Health Visits Medical Insurance
5				

Form HCFA-1533 (2/83)

☆U.S. GOVERNMENT PRINTING OFFICE 1983-381-997/4554

EXPLANATION OF ITEMS 1 2 AND 3

1 PAYMENT OF BENEFITS—Payment for covered services was made on your behalf directly to the organization shown in item 1. Medicare paid for all services covered by the program except for items shown in item 2. YOUR MEDICARE HANDBOOK tells you what hospital insurance pays for in a benefit period and what medical insurance pays for in each calendar year.

Hospital insurance covers inpatient hospital care, skilled nursing facility care and home health agency visits. Home health visits are also covered by Medicare under medical insurance but the 2 benefits are handled separately.

Generally, Part B medical insurance benefits for services you may have received from a physician or supplier are not included on this record. If you have received Part B physician or supplier services, separate notices about these services will be sent to you.

2a CHARGES NOT PAID BY MEDICARE—Medicare does not always pay the full cost of covered services in a benefit period. You are responsible for the specific deductible identified, if any, in item 2 on the front of this notice. For a definition of "benefit period" and a detailed explanation of deductibles see YOUR MEDICARE HANDBOOK.

Physicians' charges are not covered by Medicare hospital insurance, but they are covered by Medicare medical insurance. If you have the medical insurance and received services in a hospital from a radiologist or pathologist (X-ray or laboratory), 80% of the reasonable charges for these services are covered. You are responsible for the remaining 20%.

Hospital insurance never pays for some charges, such as TV or telephone and private duty nursing. The added cost of a private room can be paid only if medically necessary. Medical insurance never pays for some charges, such as meals delivered to the home and fulltime nursing care. YOUR MEDICARE HANDBOOK describes these non-covered items in more detail.

2b OTHER HEALTH INSURANCE—If you have other health insurance, you may use this notice to claim the other insurance benefits. Since the insurance company may keep this notice, you may wish to make a record or copy before sending it to them. If a breakdown of billing charges is needed, you may obtain one from the facility shown in item 1.

3 BENEFITS USED THIS TIME—Item 3 only shows the number of covered days or visits furnished by the organization and for the period, shown in item 1. If you received other covered services before or after that date, separate notices about those benefits will be sent to you. A separate notice is sent each time payment for covered services is made on your behalf.

Days or visits still available in the benefit period or in the calender year will not be paid for unless all Medicare requirements are met. The law does not cover all types and levels of institutional and home care. For a detailed explanation of Medicare requirements, see YOUR MEDICARE HANDBOOK.

GENERAL INFORMATION

A. Your Right to Reconsideration of this Medicare Benefit Determination

If you believe that Medicare should have covered more of your expenses, please ask the office shown at the bottom of Item 2 for an explanation.

You may also request a reconsideration or review of the decision. The request must be made not later than 60 days from the receipt of this record for hospital insurance expenses or not later than 6 months from the date shown on the other side of this record for home health medical expenses. The request should be sent to the office shown below Item 2. If you are not satisfied with the reconsideration or review, you may request a hearing which must be made not later than 60 days from the receipt of the notice of reconsideration for hospital insurance expenses or not later than 6 months from the date shown on a notice of review for medical expenses.

B. For More Information

If you have any questions not answered in YOUR MEDICARE HANDBOOK, please call or write the office shown below Item 2. The people there will be glad to help you. If you write, be sure to include your Health Insurance Claim Number exactly as it appears on this record.

Blue Cross
of Washington and Alaska

P.O. Box 327
Seattle, Washington 98111
(206) 367-1000

Explanation of Benefits

02/21/84

Subscriber: WALTER HUBER
4208 218TH EAST
SUMNER
WA 98390

Patient: WALTER HUBER
Provider: TACOMA GEN HOSP
Claim Number: 4045051821
Date(s) of Service: 12/27/83--12/31/83

This form explains how we processed your recent claim. It is not a billing. If you disagree with the disposition of your claim and our Customer Service Department confirms the original denial, you may request *in writing* a formal review of your claim.	**Benefit Calculations**	**Your Blue Cross Program Pays**
1. Total Charge by Your Provider of Care	1,541.70	
2. **Basic Benefits Provided by Your Program** HOSPITAL SERVICES		304.00
3. **Total Basic Payment**		304.00
4. Balance of Charges		
5. Less Charges Not Allowed Under the Provisions of Your Program	1,237.70	
Remarks: THE NON-ALLOWABLE CHARGE REPRESENTS THE AMOUNT PAYABLE BY YOUR OTHER CARRIER, THE AMOUNT CREDITED TOWARD YOUR MAJOR MEDICAL DEDUCTIBLE (IF APPLICABLE) AND ANY AMOUNT NOT COVERED BY EITHER CARRIER.		
6. **Major Medical Benefits Provided by Your Program** — Eligible Expense		
7. Amount of Deductible Required by Your Program		
8. Amount of Your Deductible Previously Satisfied		
9. Amount Credited to Your Deductible on This Claim		
10. Total Amount Eligible for Payment After Your Deductible is Satisfied		
11. **Major Medical Benefits are Payable at % of the Amount Shown in Line 10 Above**		
12. **Total Blue Cross Payment to be Sent to Your Provider**		304.00

To date this **has satisfied** **of the** **deductible for 19**

When inquiring about your claim, always give your group and identification numbers.

Group No. OCCAS Subscriber Identification No. 000093895

84.011 11.34.29 0208 0083 0

TACOMA GENERAL HOSPITAL 91-1088895-A U46
P.O. BOX 5277
TACOMA, WASH 98405
206 383-3653

PAGE NO.
1

HOSP. NO.

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL INP.	01/10/84	

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
HUBER ,WALTER L	2785277	M		12/27/83	01/01/84	5

GUARANTOR NAME AND ADDRESS

WALTER L HUBER
4208 218 EAST
SUMNER WA 98390

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MEDICARE A A83		536104978A
1	MEDICARE B		536104978A

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT	$

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
12/27	DIGOXIN RIA	4507804	12.90	12.90				
12/27	ROUTINE UA	4708936	5.10	5.10				
12/27	PUNCTURE	7700150	14.05	14.05				
12/27	BLOOD GAS KIT(S)	7701503	4.00	4.00				
12/27	OXY THERAPY SETUP	7701504	9.10	9.10				
12/27	OXY THER PER HOUR	7701505	28.00	28.00				
12/27	ANALYSIS	7702102	5.00	5.00				
12/27	ROOM 0616		225.00	225.00				
12/28	ACID PHOS W PROS	4508356	25.80	25.80				
12/28	SMA 18/60	4508780	5.30	5.30				
12/28	WESTERGREN ESR	4708718	3.40	3.40				
12/28	VENAPUNCTURE	5207558	8.95	8.95				
12/28	VENAPUNCTURE	5207558	8.95	8.95				
12/28	EQUIP STANDBY/DAY	7700500	3.00	3.00				
12/28	ROOM 0616		225.00	225.00				
12/29	CHEST PA/LATERAL	6007101	37.40	37.40				
12/29	COMPLETE ECHOCARD	6076620	169.80	169.80				
12/29	EQUIP STANDBY/DAY	7700500	3.00	3.00				
12/29	ROOM 0616		225.00	225.00				
12/30	DIGOXIN RIA	4507804	12.90	12.90				
12/30	SMA 18/60	4508780	5.30	5.30				
12/30	ROOM 0616		225.00	225.00				
12/31	VENAPUNCTURE	5207558	8.95	8.95				
12/31	PHARMACY ORIGINAL	7000001	42.30	42.30				
12/31	ROOM 0616		225.00	225.00				
01/01	PHARMACY ORIGINAL	7000001	3.50	3.50				
POLICY DEDUCTIBLE				304.00CR				304.00
TOTALS			1541.70	1237.70				304.00

PATIENT NUMBER
2785277

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT	304.00

TACOMA GENERAL HOSPITAL 91-1088895-A U46
TACOMA, WASH

84.011 11.34.40 0209 0084 0

TACOMA GENERAL HOSPITAL 91-1088895-A U46
P.O. BOX 5277
TACOMA, WASH 98405
206 383-3653

PAGE NO.
2

HOSP. NO.

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL INP.	01/10/84	

A S PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
HUBER ,WALTER L	2785277	M		12/27/83	01/01/84	5	

GUARANTOR NAME AND ADDRESS

WALTER L HUBER
4208 218 EAST
SUMNER WA 98390

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MEDICARE A A83		536104978A
1	MEDICARE B		536104978A

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT	$

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
	SUMMARY OF CHARGES							
	R&C SEMI-PR 5DAYS@225.00DAY		1125.00	1125.00				
	LABORATORY	4070	97.55	97.55				
	RADIOLOGY	4140	207.20	207.20				
	PHARMACY	4170	45.80	45.80				
	RESP THPY	4180	66.15	66.15				
	SUB-TOTAL OF CHARGES		1541.70	1541.70 ✓				
	POLICY DEDUCTIBLE			304.00CR				304.00
	DSCH/FINAL DIAGNOSIS: 428.9							
	PROCEDURE: 88.72 12/29/83							
TOTALS			1541.70	1237.70				304.00

To Be Kept
For Your Record

PATIENT NUMBER
2785277

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT	304.00

TACOMA GENERAL HOSPITAL 91-1088895-A U46
TACOMA, WASH

Blue Cross
of Washington and Alaska

P.O. Box 327
Seattle, Washington 98111
(206) 367-1000

Explanation of Benefits

05/10/84

Subscriber: WALTER HUBER
4208 218TH EAST
SUMNER
WA 98390

Patient: WALTER HUBER
Provider: TACOMA GEN HOSP
Claim Number: 4109032920
Date(s) of Service: 03/05/84--03/06/84

This form explains how we processed your recent claim. It is not a billing. If you disagree with the disposition of your claim and our Customer Service Department confirms the original denial, you may request *in writing* a formal review of your claim.	**Benefit Calculations**	**Your Blue Cross Program Pays**
1. Total Charge by Your Provider of Care	2,742.75	
2. **Basic Benefits Provided by Your Program** HOSPITAL SERVICES		356.00
3. **Total Basic Payment**		356.00
4. Balance of Charges		
5. Less Charges Not Allowed Under the Provisions of Your Program	2,386.75	
Remarks: THE NON-ALLOWABLE CHARGE REPRESENTS THE AMOUNT PAYABLE BY YOUR OTHER CARRIER, THE AMOUNT CREDITED TOWARD YOUR MAJOR MEDICAL DEDUCTIBLE (IF APPLICABLE) AND ANY AMOUNT NOT COVERED BY EITHER CARRIER.		

6. **Major Medical Benefits Provided by Your Program**	Eligible Expense		
7. Amount of Deductible Required by Your Program			
8. Amount of Your Deductible Previously Satisfied			
9. Amount Credited to Your Deductible on This Claim			
10. Total Amount Eligible for Payment After Your Deductible is Satisfied			
11. **Major Medical Benefits are Payable at % of the Amount Shown in Line 10 Above**			
12. **Total Blue Cross Payment to be Sent to Your Provider**			356.00

To date this **has satisfied** **of the** **deductible for 19**

When inquiring about your claim, always give your group and identification numbers.

Group No. NCOAS Subscriber Identification No. 000093895

84.094 13.47.59 2738 0203 0

TACOMA GENERAL HOSPITAL 91-1088895-A U46
P.O. BOX 5277
TACOMA, WASH 98405
206 594-1133

PAGE NO.	HOSP. NO.
1	

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL INP.	04/02/84	

A X M PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
HUBER ,WALTER L	2820157	M		03/05/84	03/06/84	1

GUARANTOR NAME AND ADDRESS

THE ESTATE OF W L HUBER
4208 218TH EA
SUMNER,WA 98390

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MEDICARE A A84		536104978A
1	MEDICARE B A34		536104978A

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
03/02	INTRAVENOUS SUPPL	7010001	23.25	23.25				
03/05	MONITOR	3990233	18.30	18.30				
03/05	CANNULA	3992241	4.40	4.40				
03/05	OXYGEN PER HOUR	3992253	1.80	1.80				
03/05	GLUCOSE	4508722	4.80	4.80				
03/05	GLUCOSE	4508722	4.80-	4.80-				
03/05	ELECTROLYTES	4508776	5.70	5.70				
03/05	ELECTROLYTES	4508776	5.70-	5.70-				
03/05	SMA 18/60	4508780	6.00	6.00				
03/05	SMA 18/60	4508780	6.00	6.00				
03/05	COMP BLOOD COUNT	4708628	13.35	13.35				
03/05	COMP BLOOD COUNT	4708628	13.35-	13.35-				
03/05	CPK ISOENZYMES	5107679	25.00	25.00				
03/05	CPK ISOENZYMES	5107679	25.00	25.00				
03/05	CPK ISOENZYMES	5107679	25.00	25.00				
03/05	VENAPUNCTURE	5207558	9.10	9.10				
03/05	STAT BLOOD COUNT	5307589	11.25	11.25				
03/05	STAT GLUCOSE	5307593	12.00	12.00				
03/05	STAT ELECTROLYTES	5307596	14.25	14.25				
03/05	EKG CHARGE	5500001	21.25	9.25	12.00			
03/05	EKG CHARGE	5500001	21.25	9.25	12.00			
03/05	CH SINGLE PA TELE	6007100	28.80	28.80				
03/05	PORT X-RAY UNIT	6007551	15.20	15.20				
03/05	EMERG SERVICE RX	7000002	6.00	6.00				
03/05	INTRAVENOUS SUPPL	7010001	21.25	21.25				
03/05	CRITICAL CARE TMT	4404008	500.00	500.00				
03/05	IV START	4404011	15.00	15.00				
03/05	IV MED SIMPLE ADM	4404012	15.00	15.00				
03/05	IV MED SIMPLE ADM	4404012	15.00	15.00				
03/05	IV MED SIMPLE ADM	4404012	15.00	15.00				
03/05	IV MED SIMPLE ADM	4404012	15.00	15.00				
03/05	EKG MONITORING	4404021	15.00	15.00				
03/05	CATH FOL TRAY 16	3900487	21.50	21.50				

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

84.094 13.48.08 2739 0204 0

TACOMA GENERAL HOSPITAL 91-1088895-A U46
P.O. BOX 5277
TACOMA, WASH 98405
206 594-1133

PAGE NO.
2

HOSP. NO.

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL INP.	04/02/84	

A X M PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
HUBER ,WALTER L	2820157	M		03/05/84	03/06/84	1

GUARANTOR NAME AND ADDRESS

THE ESTATE OF W L HUBER
4208 218TH EA
SUMNER,WA 98390

C.O.B.	INSURANCE COMPANY NAME		GROUP NUMBER	POLICY NUMBER
1	MEDICARE A	A84		536104978A
1	MEDICARE B	A34		536104978A

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
03/05	MISC MED/SURG SUP	3900778	2.00	2.00				
03/05	TUBE HOLDER	3904404	.85	.85				
03/05	ELECTRODES ECG	3908355	8.00	8.00				
03/05	OXY THERAPY SETUP	7701504	9.10	9.10				
03/05	OXY THER PER HOUR	7701505	42.00	42.00				
03/05	ROOM K470	1100001	790.00	790.00				
03/06	CARDIAC OUTP COMP	1900021	26.25	26.25				
03/06	A-V PRES MONITOR	1900023	14.70	14.70				
03/06	VENAPUNCTURE	5207558	9.10	9.10				
03/06	VENAPUNCTURE	5207558	9.10	9.10				
03/06	VENAPUNCTURE	5207558	9.10	9.10				
03/06	VENAPUNCTURE	5207558	9.10	9.10				
03/06	CH SINGLE PA TELE	6007100	28.80	28.80				
03/06	CH SINGLE PA TELE	6007100	28.80	28.80				
03/06	TECH (EA) 1HR	6007512	40.00	40.00				
03/06	PORT X-RAY UNIT	6007551	15.20	15.20				
03/06	PORT X-RAY UNIT	6007551	15.20	15.20				
03/06	C-ARM EQUIP	6007700	148.80	148.80				
03/06	PHARMACY ORIGINAL	7000001	99.10	99.10				
03/06	INTRAVENOUS SUPPL	7010001	103.75	103.75				
03/06	TOPPER 4X4 DRESS	3900118	.80	.80				
03/06	SWABS IODOPHOR PA	3900153	2.00	2.00				
03/06	OP SITE DRESSING	3900166	11.85	11.85				
03/06	TRAY PAC ARGON	3900206	72.25	72.25				
03/06	ENDOTRACHEAL TRAY	3900352	19.80	19.80				
03/06	IRRIGATION TRAY	3900551	4.20	4.20				
03/06	MISC MED/SURG SUP	3900778	2.00	2.00				
03/06	CATH 7F SWANZ GAN	3902405	74.90	74.90				
03/06	CATH SWAN GANZ VP	3902409	148.20	148.20				
03/06	ADAPTER COBE	3902906	1.90	1.90				
03/06	URI-METER	3905151	22.40	22.40				
03/06	MISC MED/SURG SUP	3908901	1.70	1.70				
03/06	PUNCTURE	7700150	14.05	14.05				
03/06	EQUIP STANDBY/DAY	7700500	3.00	3.00				

Verna L. Huber

PATIENT NUMBER

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

84.094 13.48.18 2740 0205 0

TACOMA GENERAL HOSPITAL 91-1088895-A J46
P.O. BOX 5277
TACOMA, WASH 98405
206 594-1133

PAGE NO.	HOSP. NO.
3	

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL INP.	04/02/84	

A X M PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
HUBER ,WALTER L	2820157	M		03/05/84	03/06/84	1

GUARANTOR NAME AND ADDRESS

THE ESTATE OF W L HUBER
4208 218TH EA
SUMNER,WA 98390

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	MEDICARE A A84		536104978A
1	MEDICARE B A34		536104978A

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
03/06	BLOOD GAS KIT(S)	7701503	4.00	4.00				
03/06	CONT VENT SETUP	7701803	23.65	23.65				
03/06	CONT VENT/HR	7701804	12.90	12.90				
03/06	THERAPIST 1/4 HR	7702025	11.60	11.60				
03/06	ANALYSIS	7702102	5.00	5.00				
03/07	INTRAVENOUS SUPPL	7010001	5.00	5.00				
03/07	INTRAVENOUS SUPPL	7010001	10.00	10.00				
POLICY DEDUCTIBLE				356.00-				356.00
COINSURANCE					4.80-			4.80
TOTALS			2766.75	2386.75	19.20			360.80

Verna L Huber

PATIENT NUMBER
2820157

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT 360.80

TACOMA GENERAL HOSPITAL 91-1088895-A J46
TACOMA, WASH

84.094 13.48.25 2741 0206 0

TACOMA GENERAL HOSPITAL 91-1088895-A U46
P.O. BOX 5277
TACOMA, WASH 98405
206 594-1133

PAGE NO.	HOSP. NO.
4	

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
FINAL INP.	04/02/84	

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DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
SUMMARY OF CHARGES								
R&C MINIMAL 1DAYS@790.00DAY			790.00	790.00				
	EMERGENCY RM	4230	614.50	614.50				
	MED-SURG SUP	4050	394.35	394.35				
	LABORATORY	4070	170.00	170.00				
	RADIOLOGY	4140	320.80	320.80				
	EKG	4111	42.50	18.50	24.00			
	PHARMACY	4170	268.35	268.35				
	RESP THPY	4180	125.30	125.30				
	SPECIAL CARE	3010	40.95	40.95				
SUB-TOTAL OF CHARGES			2766.75	2742.75	24.00			
POLICY DEDUCTIBLE				356.00-				356.00
COINSURANCE					4.80-			4.80
DSCH/FINAL DIAGNOSIS: 410.4								
PROCEDURE: 89.64 03/06/84								
96.04 03/06/84								
TOTALS			2766.75	2386.75	19.20			~~360.80~~ 0

MEDICARE HAS BEEN BILLED 2766 75

OTHER INSURANCE BILLED 356 00

AFTER MEDICARE PAYMENT YOU WILL RECEIVE A MONTHLY STATEMENT UNTIL YOUR ACCOUNT IS PAID IN FULL.

PATIENT NUMBER
2820157

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

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PAY THIS AMOUNT ~~360.80~~

TACOMA GENERAL HOSPITAL 91-1088895-A U46
TACOMA, WASH

7/26

Invested Aetna annuity payment
#3 in 30 month Certificate with Puget
Sound NB. Dated 7/13/82 @ 14.55

Placed in safe deposit box at
Bank of California —

Added $5000 to above ctf.
VH

July 13, 1982
Aug
Sept
Oct
Nov.
Dec
— 12mo 1983
12mo 1984 Due Dec. 13, 1984 ?